



**North Carolina Department of Health and Human Services
NC Division of Medical Assistance - Program Integrity**

BEHAVIORAL HEALTH: INDEPENDENT MH SA PROVIDER TOOL REVIEW GUIDELINES

ADMINISTRATIVE DETERMINATION:

Q1 – Referral:

Referral must be from one of the following: Community Care of North Carolina/Carolina Access primary care provider, Medicaid-enrolled psychiatrist or local management entity for recipients under 21.

Referrals for recipients 21 and over may be self-referred or referred by some other source.

Q2- Authorization

- The Provider either needs to provide an authorization from VO or an agency contact list of unmanaged/managed visits for outpatient therapy visits. If the agency provides an agency contact list and the number of visits goes beyond the unmanaged phase of visits, then an authorization needs to be provided.
- Score as N/A if an unmanaged/managed list is provided AND provider has not exceeded the 26 sessions for recipients under age 21 or 8 sessions *for* recipients 21 and older.
- As a result of action by the General Assembly, the 26 unmanaged visits for children will decrease to 16 unmanaged visits effective January 1, 2011 (See IU #80) .
- Score as Not Met if there is not an authorization or unmanaged/managed list provided.
- Effective September 20, 2010, in addition to ValueOptions, Medicaid services for MH/SA/DD will be reviewed for prior authorization by The Durham Center and Eastpointe LME's for their respective catchment areas only.
- 90801, 90802, H0001, H0031----Score N/A – NOTE: Only mark as NOT MET for these codes when there is no managed/unmanaged visit list and no authorization. Otherwise, score these as N/A.

Q3 – Service Order:

- Score this as N/A (instead of Met) if provider has not exceeded the 26 unmanaged sessions for clients under age 21 years or 8 unmanaged sessions for clients 21 and older; however, this MUST be verified by the unmanaged/managed visits list provided. If the provider fails to submit the required list, this is scored as Not Met.
- As a result of action by the General Assembly, the 26 unmanaged visits for children will decrease to 16 unmanaged visits effective January 1, 2011 (see IU #80).
- Either a SO or unmanaged/managed visit list MUST be provided to score this item as Met.
- Valid signatures on a SO should be from one of the following: medical doctor, licensed psychologist (doctorate level), nurse practitioner, or physician assistant.
- SO must be signed and dated before the DOS being reviewed.
- If the agency provides an agency contact list and the number of visits goes beyond the unmanaged phase of visits, then a valid service order needs to be provided.
- SO's must be signed and dated either via handwritten signature or by "Official" electronic signature method. In order to accept the Electronic Signature method, the agency would have to provide an agency policy on the electronic health records and a list of staff authorized as having an electronic record.
- In order for this item to be scored as "MET," the following **MUST** apply:
 1. Must be signed by an MD, DO, PhD in Psychology, Nurse Practitioner, Physician's Assistant
 2. Must have order for the appropriate service. (The service needs to be identified in the Action Plan of the PCP to be ordered via signature on the PCP).
 3. Must have signature and date handwritten by the signatory.
 4. Must have dates handwritten by the signatory (can be entered by another person or typed in if signatory signs and dates handwritten versions on same form)
 5. Must be submitted with a verified Americans with Disabilities Act (ADA) exception if date/signature is stamped (if no stamp, disregard this)
 6. Must be submitted with agency policy on electronic health records and a list of staff/staff signature log (if no electronic signature, disregard this)
 7. Must be dated **ON or AFTER** the Date of Plan / when PCP is completed.
 8. the Service Order is signed on or before the date of service, but never before the Date of Plan
 9. Must be dated less than 1 year before DOS *unless* a new service is added (if a new service has been added, the signature must have been updated at date new service was added)
 10. Must have both boxes checked regarding face to face contact/assessment review, however both boxes do not have to be checked "yes."
 11. For consumers receiving basic services only, the SO is provided on a separate document.

- 90801, 90802, H0001, H0031----Score N/A-NOTE: Only mark as NOT MET for these codes when there is no managed/unmanaged visit list and no authorization. Otherwise, score these as N/A.

Q4-Consent

- The provider is responsible for obtaining written consent for treatment for recipients of all ages at the time of initial service or prior to date of service.
- Consent MUST be signed prior to or on the DOS.
- For SA recipients only – clients under age 21 are allowed to sign their own consent for treatment without a guardian’s signature if SA treatment services are provided
- A consent must be signed; however, it is not required to have a dated signature but there must be a date somewhere on the form.
- Court documentation must be provided to verify DSS custody. Additionally, that documentation of DSS custody must be updated every 6 months or the minor is not in the custody of anyone.
- Anyone 18 years and older can sign their own consent for treatment (and their own treatment plans).
- The consent needs to specify consent to be treated by that agency and does not need to identify specific services the individual is consenting to receive.

Q5-Valid Treatment Plan or PCP

Treatment plan must be:

- consistent with and supportive of the service provided and within professional standards of practice
- required on or before the day the service is delivered
- If no PCP or treatment plan is provided, score this item as NOT MET.

If a PCP is provided:

- The LP or QP who writes the PCP and the legally responsible person (lrp) must sign the plan at creation and each time there is a review or revision.
- In order for a PCP to be valid, there must be a CCA in the medical record. If there is no CCA, this item should be scored as not met.
- Must begin at admission and rewritten annually.
- Must be completed by a Qualified Professional or Licensed Professional (must verify that plan creator is qualified as a QP. If not, score this item as NOT MET)
- PCP must be updated (this means reviewed)/revised when:
 - Needs of person have changed (i.e. service reduced/terminated);
 - On or before target dates
 - Treatment needs have significantly increased and/or symptoms have become significantly more severe

- When provider changes (Revision date no later than date new provider began services)
- When a service note in record indicates that a review or revision has taken place
- Plan target dates must be within the 12 month/annual time period.
- The annual target date must be listed correctly at minimum on the first entry (if it is not carried over on subsequent lines, don't score as not met). If the target date and PCP date are the same, score this item as NOT MET as plan is invalid. Review dates on various lines of the PCP must be entered correctly.
- Signatures must be obtained for each required/completed review or revision, even if no change occurred. The service order does not need to be updated unless a new service has been added to the plan.
- If the legally responsible person didn't sign the PCP until after service date, there must be documented explanation and evidence of ongoing attempts to obtain signature.
- PCP signatures must be dated on or before the date of service, but never before the Date of Plan.
- Documentation of the legally responsible person, if not the parent, needs to be provided (Court ordered guardianship, court-appointed custody to DSS, power of attorney). In order for PCP to be valid for a recipient in DSS custody, a DSS agent should have a letter from the DSS agency director which states that the agent has permission to sign documents on behalf of the DSS Director.
- If a minor is cared for by someone other than a parent, and evidence of intention for long-term care is present, this can be accepted as "in loco parentis" in lieu of documented legal guardianship. This care type is considered met unless there is direct evidence to the contrary provided in consumer record.
- Crisis plan must be included and/or attached.
- Must include a valid service order
- Must be completed on the correct form version (check in document footer for form version)
 - All PCPs until 2008 use form version 9/11/06.
 - Existing consumers on the 9/11/06 PCP format required transfer onto the new Complete PCP either at their next revision or the annual medical necessity review. **All existing consumers must be on the new Complete PCP (Version 2008) no later than June 30, 2008**
 - PCPs Signature pages for juvenile justice involved youth must be completed on the 8.1.08 version of the signature page effective 8.1.08.
 - PCPs 3/1/09 forward use the 2008 version- Revised 2/09 as follows:
 - The PCP formats (Introductory and Complete) and the 2008 Instruction Manual became effective March 1, 2009 for all services which require a PCP, except for CAP-MR/DD service plans.
 - The effective date for CAP-MR/DD plans to be completed using the PCP format is for PCPs due for July 2009 birthdays.
 - NOTE: Implementation Update #51 indicates that, *"The revised documents will have an effective implementation date of January 1, 2009;*

this means that any PCP annual review that is due in January of 2009 will need to be updated on the new forms. Revisions will not be subject to the new forms, only the annual plan.

- The new documents are now effective March 1, 2009.
 - Any Introductory PCP, Complete PCP or PCP annual review that is due in March of 2009 will need to occur using the new format.
 - It will also be necessary to use the new Update/Revision form for any reviews taking place in March 2009. The only significant change to this form is the signature page. If a new service is added to a PCP as a result of a review and update/revision to the plan, Part 1, Section A of the Signature Page, with the new check boxes must be used.
- Beginning March 1, 2010, for all other services requiring a PCP, the new format (Version 3.1.10) **MAY** be used **when the next annual re-write of the PCP is due**. Beginning July 1, 2010, the new format **MUST** be used **when the next annual re-write of the PCP is due**.
- For example, if the date on the current PCP is March 12, 2009, the annual rewrite is due by March 12, 2010 and MAY be completed using the new format. The annual rewrite due the next year, March 12, 2011 MUST be on the new format.
 - If the date on the current PCP is August 10, 2009, the annual rewrite is due by August 10, 2010 and MUST be on the new format.
 - As of March 1, 2010, there will be **no use of an Introductory PCP** for people new to our system. Service plans for people newly admitted for mental health, developmental disability or substance abuse services on or after March 1, 2010 must be prepared using the new PCP format when a PCP is required. Submission of a prior authorization request with an Introductory PCP on or after March 1, 2010 will be returned by ValueOptions as Unable to Process.
 - The PCP must include all services that the person receives, but a PCP is not required if only Basic services are being provided (outpatient treatment and medication management). If an individual is receiving any service which requires a PCP, then the Basic benefit service must be included in the PCP, and no separate plan may be used.
- PCP is invalid if the assessment provided is dated after the plan date.
 - 90801, 90802, H0001, H0031----Score N/A

Q6-Documentation Signed by the person who provided the service

- Look for the signature and date of the person who provided the service.

- If no signature, score the item as “No/Not Met”.
- Documentation completed within 24 hours from date of service
- Late entry note completed within 7 days from the date of service

Q7-Documentation reflect intervention/treatment

- Must be appropriate in content and time
- Intervention/treatment is clearly documented and described in the service note
- The amount of time can be justified by the treatment or intervention provided
- Correct or ameliorate a mental illness or a condition
- 90801, 90802, H0001, H0031----Score N/A

Q8-Service note reflect client’s response to therapy

- PROGRESS MUST BE DOCUMENTED
- “No progress noted” is to be scored as “Yes/Met”
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient’s needs
- Correct or ameliorate a mental illness or a condition
- 90801, 90802, H0001, H0031----Score N/A

Q9-Documentation reflect the service billed

- The procedure billed must match the service note procedure code documented.
- The description of the intervention or service provided should also match the procedure code billed

Q10-Service note reflect the specific treatment goal

- If the goal in the service note does not reflect the exact language or use the right number for a goal, review the goals in the PCP to see if it relates to one of them.
- The goal has not expired or overdue for review
- 90801, 90802, H0001, H0031----Score N/A

Q11– Qualifications and Training

- Review personnel record of staff that provided the service.
- Providers must submit a copy of the license/certification for evidence that the provider is qualified to provide the service

- Providing outpatient services working with a physician using Medicaid's "Incident To" policy (see the March 2009 Medicaid Bulletin).
- Provisional licensees may not bill CPT codes
- In addition to physician the following providers may bill for these services:
 - a. Licensed psychologist (doctorate level)
 - b. Licensed psychological associates (LPA)
 - c. Licensed Professional Counselors (LPC)
 - d. Licensed marriage and family therapists (LMFT)
 - e. Licensed Clinical Social Workers (LCSW) with a Masters degree in Social Work
 - f. Nurse Practitioners approved to practice in NC & Certified by the American Nurse Credentialing Center as Advanced Practice Nurse Practitioner and Certified in Psychiatric Nursing or Nurse Practitioners who are certified in another specialty with two years of documented mental health experience. These nurse practitioners will be enrolled under a sunset clause that will require psychiatric certification at the end of a five year period. If this certification is not obtained by June 30, 2010, enrollment will be terminated.
 - g. Clinical Nurse Specialist
 - h. Certified Clinical Supervisors (CCS)
 - i. Licensed Clinical Addictions Specialist (LCAS)

Per IU #58, Jul 9, 2009: Extension of Sunset Clause for Nurse Practitioners who Provide Outpatient Behavioral Health Services

DMA has extended the sunset clause for nurse practitioners who provide outpatient behavioral health services. DMA will allow nurse practitioners who possess an Advanced Certification in areas other than psychiatric nursing, and who have two years of mental health experience to enroll under this sunset clause. Under this clause, all nurse practitioners will be required to complete and submit the Advanced Psychiatric Certification to DMA Provider Services on or before June 30, 2015. Failure to complete the certification by June 30, 2015, will result in termination of participation in the N.C. Medicaid Program. It is DMA's expectation that all providers will practice within the scope of their licensure, training, and practice competencies. As a reminder, nurse practitioners must direct enroll with Medicaid to be eligible to provide outpatient behavioral health services to adults and children. Nurse practitioners may also provide services "incident to" a physician if they are employed in a physician's office or a physician-directed clinic. However, all behavioral health practitioner services billed under "incident to" must meet the guidelines outlined in the May 2005 Special Bulletin, *Expansion of Provider Types for Outpatient Behavioral Health Services, Phase II*, and the article titled *Modification in Supervision When Practicing "Incident To" a Physician* published in the October 2008 Medicaid Bulletin. (The general Medicaid Bulletin and the Special Bulletin are available on DMA's website at <http://www.ncdhhs.gov/dma/bulletin/>.)

Q12-Individualized:

- Review documentation showing that the service delivered is specific to the recipient based on recipient's intellectual, educational, medical/health, behavioral, and/ or Support/intervention needs.
- If conflicting pronouns occur on more than 1 occasion and/or other consumers' names/identifying information appear in the document score item as "No/Not Met"
- 90801, 90802, H0001, H0031----Score N/A